

<b>Case Number:</b>	CM15-0140464		
<b>Date Assigned:</b>	07/30/2015	<b>Date of Injury:</b>	10/29/1999
<b>Decision Date:</b>	09/02/2015	<b>UR Denial Date:</b>	06/24/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/20/2015

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
 State(s) of Licensure: Texas, New York, California  
 Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The applicant is a represented 62-year-old who has filed a claim for chronic low back pain (LBP) reportedly associated with an industrial injury of October 29, 1999. In a Utilization Review report dated June 24, 2015, the claims administrator failed to approve a request for electrodiagnostic testing of the bilateral lower extremities. The claims administrator referenced an RFA form received on June 12, 2015 in its determination. The applicant's attorney subsequently appealed. On said RFA form of June 12, 2015, electrodiagnostic testing of bilateral lower extremities was sought. On May 21, 2015, the applicant reported ongoing complaints of low back pain, 8/10, status post earlier lumbar spine surgery. The applicant reported radiation of pain to and numbness about the left leg, it was reported. The applicant's past medical history was notable for arthritis and obesity, it was reported. The applicant was on Norco and Neurontin, it was further noted. The applicant was exercising one to three times weekly, it was reported. The applicant was severely obese, with BMI of 43, it was reported. The applicant exhibited a normal heel and toe ambulation with normal muscle strength, tone, and bulk. The applicant was using a cane to move about. Electrodiagnostic testing was sought. Toward the bottom of the report, it was stated that the applicant had issues with bilateral foot numbness.

### IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

**EMG/NCV of the bilateral lower extremities to treat lumbar spine: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chapter 14 Ankle and Foot Complaints Page(s): 309; 377.

**Decision rationale:** No, the request for electro diagnostic testing (EMG-NCV) of the bilateral lower extremities was not medically necessary, medically appropriate, or indicated here. As noted in the MTUS Guideline in ACOEM Chapter 12, Table 12-8, page 309, EMG testing is deemed "not recommended" for applicants who carry a diagnosis of clinically obvious radiculopathy. Here, the applicant did, in fact, carry a diagnosis of clinically obvious radiculopathy. The applicant presented on May 24, 2015 reporting ongoing complaints of low back pain radiating into the left leg, 8/10, it was reported on that date. Numbness and tingling about the bilateral lower extremities were noted, likely representing residual radiculopathy, status post earlier lumbar spine surgery. The applicant was on Neurontin (gabapentin), presumably for residual lower extremity radicular pain complaints. The applicant's carrying a diagnosis of clinically obvious radiculopathy, thus, effectively obviated the need for the EMG component of the request. The MTUS Guideline in ACOEM Chapter 14, Table 14-6, and page 377 also notes that electrical studies are deemed "not recommended" for routine foot and ankle problems without clinical evidence of tarsal tunnel syndrome or other entrapment neuropathies. Here, however, lumbar radiculopathy was seemingly the sole item on the differential diagnosis list. There was no mention of the applicant's carrying a diagnosis or suspected diagnosis of tarsal tunnel syndrome, entrapment neuropathy, generalized peripheral neuropathy, diabetic neuropathy, etc. It was not clearly stated why electrodiagnostic testing was being sought in the face of the applicant's already carrying an established diagnosis of lumbar radiculopathy. Therefore, the request was not medically necessary.